

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01040

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician**  
**to FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01042		First <b>Bertie</b>	Middle <b>L.</b>	Last <b>Altvater</b>	Date of Death Jan. 4 1968	Hour <b>8A.M.</b>	
1. DECEASED NAME (Type or print)	2. RACE <b>Cauc.</b>	3. SEX <b>Female</b>	4. DATE OF BIRTH <b>Oct. 7, 1887 / 1878</b>	5. AGE (In years last birthday) <b>89 YRS.</b>	6. IF UNDER 1 YEAR MONTHS <b>0</b>	7. IF UNDER 24 HRS. HOURS <b>0</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <b>Howard County</b>						
10. CITY OR TOWN OF DEATH <b>Ellicott City</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>533 Wilton Ave.</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>624 S. Lakewood</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>	13b. CITY OR TOWN <b>Howard</b>	13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <b>533 Wilton Ave.</b>				
14. FATHER'S NAME First <b>William</b>	Middle <b>H</b>	Last <b>McNeal</b>	15. MOTHER'S MAIDEN NAME First <b>Louise</b>	Middle <b>Walker</b>	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16b. SOCIAL SECURITY NO. <b>213-54-2438</b>	17. INFORMANT <b>Miss Bertha G. Altvater</b>	Address <b>624 S. Lakewood Ave</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>4129</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hr.</b>	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>Arterio-mitotic cardio vascular dis</b>						<b>10 yrs.</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)							
4221		19c. MEDICAL CERTIFICATION		19d. DATE OF OPERATION	19e. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , to <b>1-3</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>1-3</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							22c. DATE SIGNED <b>1-5-68</b>
22b. SIGNATURE <b>J. Duer Moore MD</b>		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.		
22d. PHYSICIAN'S NAME (Type) <b>J. Duer Moore MD</b>		22e. ADDRESS <b>3105 Belair Rd</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/8/68</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Spring Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Easton Talbot Maryland</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>		ADDRESS <b>5305 Harford Rd.</b>		25a. REC'D BY REGISTRAR <b>DABIN</b>	25b. REGISTRAR'S SIGNATURE <b>Quarles Young</b>		

Quots

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01041

01043

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR Year 1200 P.M.	
HATTIE				BROWN JAN. 26 1968	JAN. 26 1968		
3. SEX		4. RACE		S. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
F		W		JAN 17, 1914 54 YRS.	IF UNDER 24 HRS.		
7a. BIRTHPLACE (State or foreign country) DEEP CREEK VA		7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH	Howard	
10. CITY OR TOWN OF DEATH SAVAGE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 16 Woodward St		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	Home	
13a. USUAL RESIDENCE (Where deceased admission) STATE ND		13b. CITY OR TOWN HOWARD SAVAGE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	106 Woodward St	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First Middle Last	
LAFAYETTE		WILLIAM			DELLA DOUGHERY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT	Address Sue Braun alone		
16c. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Generalized Cirrhosis DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Cirrhosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 1631							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 1961, 19, to Jan. 26, 1968, that (I) (we) last saw the deceased alive on Jan. 26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		ROBERT C. WINGFIELD, M.D.	DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED JAN. 29, 1968
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS 329 PRINCE GEORGE STREET LAUREL, MARYLAND 20810			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1-29-68	23c. NAME OF CEMETERY OR CREMATORIAL Savage Cem.	23d. LOCATION (City or Town) Savage Md			(State)
24. FUNERAL DIRECTOR DeWitt Damron Laurel Md		ADDRESS	25a. REC'D BY REGISTRAR FEB 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01042

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician. Then please remove carbon paper. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First George	Middle F.	Last Ensor	2a. DATE OF DEATH Jan. 26	2b. HOUR Year 1968 145 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH Nov 14 1883		6. AGE (In years last birthday) 84	IF UNDER 1 YEAR MONTHS    DAYS IF UNDER 24 HRS. HOURS    MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Howard		
10. CITY OR TOWN OF DEATH Ellicott City	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Shaffer Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY -	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5237 Fairlawn Ave 21215	
14. FATHER'S NAME First Franklin	Middle Ensor	15. MOTHER'S MAIDEN NAME Rickey	Middle Last Ramkey		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. 705-10-4072	17. INFORMANT Charles O. Ensor Brown Ridge Rd Highland Md.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular occlusion</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hrs		
4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic cardio-vascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22o. I certify that (I) (this hospital) attended the deceased from 1-28, 1968, to 1-26, 1968, that (I) (we) last saw the deceased alive on 1-26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Thomas F. Herbert, M.D.</i>	22c. DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 1-27-68
22d. PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.	22e. ADDRESS 511 Ellicott City, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/29/68	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Lorraine Park	23d. LOCATION (City or Town) Woodlawn	(County) Balto	(State) Md.
24. FUNERAL DIRECTOR <i>George Byers</i>	ADDRESS 5728 Libell Rd. Landais Station		25a. REC'D. BY REGISTRAR JAN 29 1968	25b. REGISTRAR'S SIGNATURE <i>George Byers</i>	

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FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01043

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First <b>EULA</b>	Middle <b>EMMA</b>	Last <b>SMITH</b>	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 1	Month 13	Day 168	Year M	2b. HOUR		
3. SEX <b>Female</b>	4. RACE <b>White</b>	S. DATE OF BIRTH <b>9-21-81</b>	6. AGE (In years last birthday) <b>87</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS DAYS <b>0</b>	HOURS <b>0</b>	MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>January</b>	Day <b>13</b>	Year <b>68</b>	2d. HOUR <b>12 M</b>
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>HOWARD</b>	(noon)					
10. CITY OR TOWN OF DEATH <b>Ellicott City</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>4 Jay Court</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Howard</b>	13c. CITY OR TOWN <b>Ellicott Cty</b>	13d. INSIDE CITY LIMITS? <b>YES</b>	13e. STREET AND NUMBER <b>1 Pierce Drive, Fort Hill</b>							
14. FATHER'S NAME First <b>Hiram B. Westcott</b>		Middle <b></b>	Last <b></b>	15. MOTHER'S MAIDEN NAME First <b>Sophia Baker</b>	Middle <b></b>	Last <b></b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>none</b>	17. INFORMANT <b>G. Westcott Potter</b>	ADDRESS <b>1 Pierce Dr. Ellicott City Maryland</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF  412.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF  (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  4221 Lacerations and contusions of head											
19a. DATE OF OPERATION <b>4221</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <b>?</b>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>? P.M. 1-13 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  <b>Apparently fell</b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>patio</b>		21f. LOCATION Street or R.F.D. No. <b>4 Jay Court, Fort Hill, Ellicott City</b>		City or Town <b>(Howard)</b>		County <b>Md.</b>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE  <i>Charles S. Springate</i>		M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>January 14, 1968</b>		
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county) <b>Ellenton Pa.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>1/17/68</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Ellenton Cem.</b>			23d. LOCATION (City or Town) <b>Ellenton</b>		(County) <b>Pa.</b>	(State)	
24. FUNERAL DIRECTOR <b>Springate, Charles S. - SLACK</b>		ADDRESS <b>ELLICOTT CITY, MD.</b>			25a. REG'D BY REGISTRAR DATE <b>JAN 17 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
REFERRED TO MORSE, F. H., CANTON, Pa.											

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Scuola di valutazione

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